**State Employee Benefits Committee**
**February 7, 2011, 2:00 p.m.**
**Tatnall Building, Room 112**
**Dover, Delaware**

The State Employee Benefits Committee met on February 7, 2011 at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

Ann Visalli, Director, OMB
Brenda Lakeman, OMB, Director, Statewide Benefits
Faith Rentz, OMB, Statewide Benefits
Ann Skeans, OMB, Statewide Benefits
Mary Thuresson, OMB, Statewide Benefits
Casey Oravez, OMB, Financial Operations
Jill Ipnar, OMB, PHRST
Mike Morfe, AON Consulting
Carolyn Berger, Justice, Supreme Court
Andrew Kerber, DAG, Department of Justice
Lori Christianson, Controller General's Office
David Gregor, Department of Finance
Jennifer Vaughn, Department of Insurance
Linda Nemes, Department of Insurance
Chip Flowers, State Treasurer
Erika Benner, State Treasurer's Office
Barb Bennett, State Treasurer's Office
Kelly Callahan, State Treasurer's Office
Henry Smith, DHSS
Kim Vincent, Office of Pensions
Chris Ulrich, University of Delaware
Mary Cook, Department of Education
Kim Hawkins, City of Dover
Katherine Impellizzeri, Aetna
Julie Caynor, Aetna
Drew Brancati, Blue Cross Blue Shield DE
Faith Joslyn, Blue Cross Blue Shield DE
Joe Marocco, HMS
Karen Valentine, AFSCME, Council 81
Michael Begatto, AFSCME, Council 81
Sandy Richards, AFSCME, Retirees
Wayne E. Emsley, DRSPA
Tom Adams, DRSPA
Tim Barchek, DSEA
Cynthia Angermeier, DSEA, Retired
Rich Phillips, DSEA, Retired
James Harrison, Retiree
Hugh Ferguson, DRSPA
David Leiter, DHSS
Judy Anderson, DSEA
Frederika Jenner, SEBAC, DSEA

Agenda Items Discussed:

**Introductions/Sign In**

Ms. Visalli called the meeting to order at 2:00 p.m. All were asked to sign in. Those who want to give public comment were asked to sign that sheet. Introductions around the room followed.

**Approval of Minutes**

Ms. Visalli asked members to review the prior meeting minutes for January 24, 2011. She asked for a motion to approve the minutes. Mr. Gregor made the motion and Mr. Smith seconded the motion. Upon unanimous voice vote the minutes were approved.

**Directors Report**

None.

**Health Fund Financials**

**Historical Trend Discussion –Mike Morfe (handout)**

SEBC requested Aon provide a history of the Health Fund financials. In 2010 they were asked to supply backup to what they were talking about in terms of underlying trend. Trend is the cost increase, quarter over quarter, year over year, that the plan experiences. The data captured begins with and following one year of experience with Aetna. Medical costs tend to increase over time and that increase has been called "medical trend." There are three components: cost per service, number of services, and mix of services. They created a year's worth of data capture by adding the newest quarter and taking out the oldest quarter so they always have 12 months at a time. There are 10 data points from FY ending 2008 through FY ending 2010 and the first quarter of FY 2011. The overall average cost is divided by the average number of members to reach the "per member per month cost." They believe there is an underlying trend force that drives those data points up. They used the best fit model to attempt to ascertain what the underlying trend is for those data points. Using the ten data points and the best fit model, to the percentage increase over time trend, we arrive at an average trend of 7.4 percent. On average, year over year costs have been going up by 7.4 percent. From the quarterly consultant reports Aon does, we know it fluctuates. Looking toward budgeting for FY 2012, the reasonable rate of trend for the plan continues to be 6 to 8 percent. Controller General Larson had requested this information.

Ms. Visalli asked what is being seen around the country for other state trends. We appear in the region to be the lowest trending due to aggressive things we've done. Mr. Morfe stated that those who have not been aggressive with their plan are seeing a seven to ten percent realized trend before plan changes are made. You can see that in some surveys Aon has done. If you look at other consulting firms' surveys, you may see numbers five to eight percent. When you look under further, those are costs after plan sponsors made plan changes. If you filter out the plan changes that were made, typically the underlying trend component being see is seven to ten percent. You are more favorable than state and other plan sponsors we deal with and monitor. Secretary Flowers asked if Mr. Morfe could give him the actual formula used for the line and Mr. Morfe explained it in detail.

Since the next item would require a vote, Ms. Visalli explained they would go through the next agenda item, read the SEBAC comments, have public comments, and then call the vote for the Committee.

**FY 2012 Group Health Planning**

**Administration of Dependent Coverage to Age 26 Policies – Brenda Lakeman (handout)**

This was discussed at the last meeting regarding extending coverage to age 26 as of July 1, 2011. One of the options allowed as a grandfathered plan is to exclude adult children who are eligible for coverage under their own employer's health plan through July 1, 2014. We modeled the policy after the spousal coordination of benefit (COB) policy which is in place now. In order to certify that an employee's dependent who turned 21 prior to the end of the preceding calendar year is, or is not, covered by a plan where the dependent is employed, all employees who enroll for Employee & Children or Family coverage MUST complete the Dependent Verification of Employer Coverage Form:

- upon enrolling the dependent who turned 21 prior to the end of the preceding calendar year;
- during subsequent open enrollment periods; and

- within 30 days of any change to the dependent's employment which impacts their eligibility for benefits as described below.

*The form must also be completed at the end of the calendar year in which an enrolled dependent turns 21.*

A dependent does not need to be enrolled in the health care plan where he or she works if ONE of the following reasons is applicable:

- The dependent is less than 21 or turned 21 in the current calendar year; or
- The dependent is less than 24 and is a full-time student; or
- The dependent does not work full-time; or
- The dependent is not eligible for benefits under the employer's health care plan because they have not satisfied his or her employer's requirements as to the number of hours worked; or
- The dependent's employer requires a contribution of more than 50% of the premium for the lowest benefit plan available through his or her own employer; or
- The dependent's employer does not offer medical coverage.

Justice Berger asked two questions concerning how COB works and gave scenarios. Ms. Lakeman fully explained how each situation would be handled and stressed that they are looking to do the same thing for dependents as for spouses for COB.

Ms. Lakeman explained that every time someone enrolls their spouse in the current plan we mandate they complete a spousal COB form. It would be the same with this policy. In May, if you enroll your dependent who is 25 and you do not complete the form, we will consider your dependent secondary until you do complete the form. Explanation with examples followed. Treasurer Flowers asked if there was the ability to retroactively enroll a dependent as primary if someone filled out the form late and did it affect their status of eligibility to participate? Ms. Lakeman explained the process of notification by letter informing the employee the form was required or a sanction would be applied. Once the forms are received, the sanction would be removed and primary coverage would be applied retroactively. If they did not complete and return the form until very late, say January, and requested primary coverage to be retroactive to July of the previous year, the request would be denied. Primary coverage would become effective beginning the first of the prior month due to issues with paying claims more than 60 days in arrears with the carriers. Treasurer Flowers also asked about the 50 percent rule and spouses that have a lesser plan and coverage. Ms. Lakeman explained for example, if a benefit level only paid 60 percent of your allowable charge, then the state would pay the other 40 percent as secondary. Ms. Visalli added, if the spouse is required to pay more than 50 percent of the plan, they can be covered as primary on ours. The same logic would apply with the dependent policy.

**SEBAC Comments**

Ms. Rentz read SEBAC comments on this item. "The SEBAC supports adopting a similar policy for dependent coordination of benefits as is in place for spousal coordination of benefits."

Being no Public Comments on this issue, Ms. Visalli entered a motion to adopt this policy for the Dependent Coverage to Age 26. Mr. Gregor (for Secretary Tom Cook) made the motion and Ms. Christiansen (for Controller General Russ Larson) seconded the motion. Upon unanimous voice approval the motion carried.

**Consumer Driven Health Plan Discussion – Mike Morfe (PowerPoint presentation/handout)**

Ms. Visalli provided opening comments and stated that this was an issue the Committee had talked about for years. This type of plan allows the participant to play a more active role as a consumer in their health care. A Consumer Driven Health Plan (CDHP) comes in two general forms. With either a health reimbursement account or a health savings account. A health savings account allows a member to take funds with them when they are no longer covered under the plan. The health reimbursement account allows a member to accumulate money in their account year after year and draw down against it for things like co-pays. They tried to develop a model that fits within the current plan offerings available. A model was presented and explained as another option to be available in during the 2011 Open Enrollment.

Overall Objective

- Effective July 2011 - Introduce Consumer Driven Health Plans (CDHP) as an added option for all eligible employees and non-Medicare eligible retirees
- Offer CDHP option at affordable contribution levels
- Introduce plan design that is more supportive of DelaWELL objectives
  - Eventual incentive payment can supplement account
- Promote CDHP implementation with aggressive communication campaign and tools
- Design CDHP with BCBSD and Aetna

Plan Design Changes for All Employees – FY12

- Aon Hewitt believes that a CDH strategy is tactically viable for the Plan
- BCBS and Aetna must be allowed to offer under direction of the Deputy Attorney General until next bid process
- We recommend the following:
  - Implement CDH as an option competitive with HMO benefit level
  - Position "CDH Gold" contributions at affordable contribution level of $18 for employee-only and corresponding contributions on other tiers
  - Support contribution rates and anticipated plan costs with better utilization controls from CDH platform

Why CDHP? Key Data Points*

- Medical cost trend tends to be lower for CDHP offerings, "bending the curve" on trend
- Use of preventive care increases
- Use of "best practice" medicine is constant or improved
- Cost reduction prevalent for those with chronic disease states
- More engaged health management

Plan Design Changes – CDHP Construction

- CDHP platform is similar to a PPO – like the First State Basic and PPO offerings currently, with an in-network and out-of-network component
- Key component of CDHP is consumerism tools; both Aetna and BCBS currently offer CDHP and will offer their tools to enrolled members
- CDHP can be constructed with a Health Reimbursement Account or a Health Savings Account
  - Recommending HRA account for implementation, precluding need to prospectively fund the account
  - Less administrative and tactical burden
  - Rollover of HRA amounts will be allowed with continuation in CDHP

- Offering will include Medco prescription drug benefit identical to all current offerings; Rx benefit remains unchanged

AonHewitt Survey of Plan Sponsors offering CDHP

- Most popular reasons for offering CDHPs were:
  - Increase consumerism
  - Contain health care costs
- Most plans had an out-of-pocket maximum between $2000 and $4000 (76% for those with an HRA plan design)
- Most popular deductible range was $1500 to $2000 (approximately 40%)
- Majority (67%) used favorable contribution rates as an incentive to enroll
- Slightly less than half are HSA oriented (57 of 126)
- Most Plan Sponsors offered CDHPs as an option to other plans (92%)

CDH Gold Plan Components

- Health Reimbursement Account (HRA) $1250 single/$2500 w/dependents
- Member Responsibility (In Network) $250 single/$500 w/dependents
- Coinsurance - In Network 90% w/$3000/$5000 OOPM, excluding deductible/
  Out of Network 70% w/$6000/$12000 OOPM, excluding deductible
- Preventive Services covered at 100%
- Prescription Copays apply and are outside of CDH plan

FY12 CDH Illustrative Rates and Contributions

| | Total Monthly Rate | Employee/Pensioner Pays |
|---|---|---|
| Employee | $532.56 | $18.00 |
| Employee & Spouse | $1,104.26 | $39.60 |
| Employee & Children | $813.70 | $31.50 |
| Family | $1,402.86 | $72.00 |

Likely CDHP Enrollees

- AonHewitt reviewed the enrollment pattern of current enrollees
  - Actives are: FSB 1.5%, PPOP 51.5%, HMOs 47%
- HMO and PPO in-network plan designs are nearly identical, implying a health "platform" (PPO vs. HMO) inclination to enroll in the PPO
  - As the PPO contributions are significantly greater than the HMO contributions
- Optimally, only the lowest utilizers benefit by enrolling in the FSB plan, and the enrollment reflects this and basic risk-averse nature of individuals
- Offering the CDHP with the proposed plan design likely finds a "sweet spot" with low and medium utilizers (80% of the overall population)
  - Many will not utilize all of HRA, generating "rollover funds"
  - CDHP will be very attractive in future years as funds rollover
  - May be attractive to users with chronic conditions due to care management and 100% benefit
- All low and medium utilizers (with claim expectations of less than $10,000 per year) are likely financially advantaged to enroll in the CDHP, if they are currently enrolled in the PPO
- As many as half of PPO members may join, but more likely a quarter (or less) of PPO members
  - Inertia is an issue

    - First year enrollment may be 5% to 10% of eligibles
- HMO enrollees will not be financially incented to join CDHP

Employees Tend to Embrace CDHP Implementation When:

- Plan design is attractive and out-of-pocket limits are comparable to a competing PPO
- CDH contribution rates are less than other plans
- Existing plan options are eliminated and an "active" enrollment approach is used
- Strong networks, administrative systems, customer support, medical management and consumerism tools are incorporated
- Health coaching and disease management are included

Recommendations for Successful CDHP Implementation

- Add healthy behavior incentives – For completing health risk assessments or participating in a health coaching or disease management program
- Include provider pricing and quality data – Hospital and physician pricing and quality data will help consumers select cost effective and quality care
- Have leadership promote CDH – State leaders need to endorse and help promote the new plan to employees
- Set an enrollment goal – Develop a strategy to attain that target through aggressive communications (print, internet, meetings, hotline, one-on-ones, etc.)
- Provide an online plan selector tool – Shows employees the CDH plan out-of-pocket costs compare favorably to the other plans
- Leverage DelaWELL incentives – For completing health risk assessments or participating in a health coaching or disease management program
- Have leadership promote CDH – Endorse and help promote the new plan to employees
- Provide an online plan selector tool – Shows employees the CDH plan out-of-pocket costs compare favorably to other plans
- Plan design is attractive and compares favorably to the competing PPO
- CDH contribution rates are less than other plans
- Strong networks, administrative systems, customer support, medical management and consumerism tools are incorporated

Discussion with questions and answers were intermingled. Justice Berger stated there is an expectation you will save money and asked if a breakdown of what they spend on insurance can be provided to employees. Ms. Visalli explained that Statewide Benefits was investigating various consumerism tools and educational materials intended to assist members in making their health plan choices. More information will be provided at the next SEBC meeting.

Mr. Morfe explained that a recent analysis of out of network usage in the First Basic and PPO plans found that 99 percent of spending for both plans was in network. The average cost per person is $4,500 to $5,000. Eighty percent of the people spend less than average and 20 percent are spending more than average.

Secretary Flowers asked how the funding would work and how bills would be paid, which Mr. Morfe explained in detail. It is important to note that money allotted to a person each year that is not used is rolled over and added to the next year's HRA allocation. Unused balances will continue to roll over and accumulate over time. The money cannot be withdrawn from the health fund upon retirement. Flexible Spending Accounts can be used in conjunction with this plan. Ms. Visalli encouraged all to think and

read about this and come back with questions. There will be education about this during Open Enrollment.

**SEBAC Comments**

Ms. Rentz read their comment. "The SEBAC supports having an additional health coverage option like the CDH gold plan for state employees to choose."

**Public Comments**

Rich Phillips, President of DSEA, Retired, was glad to see a new plan option. He asked be sent copies of the presentations given today and he was told they would be sent. He noticed a date change for the next SEBC meeting and asked if it was correct. All were informed of the date and time change to be Friday, February 25th at 2:30 p.m. instead of February 21st at 2:00 p.m. Secretary Flowers noted he has a scheduling conflict.

Wayne Emsley, DRSP, asked if the cost medical services or increased use of medical services was accountable for the 7.42 percent increase. Mr. Morfe stated that trend is usually a combination of cost of services, number of services and mix of services incurred by the population. They have not done a deep analysis to determine which of these factors may be contributing to the increases in expenses. As a generalization, the costs for services in the environment have remained relatively stable. Most of the increase is being driven by utilization and mix of services being used.

At an earlier meeting he asked for information about social security numbers, which he received from Ms. Lakeman. He thanked her for supplying the information.

Dave Leiter, state employee, stated that with such a great difference in pay across the board in the pay rate structure, he thinks those with higher income could pay more as their fair share. He asked why a simple rate structure couldn't be made and gave an example using a ten percent increase at key salary increments. He feels retirees and pensioners should be left alone as they've done their share and were told they would get their benefits. For the coming year he asked what the increase will be for medical coverage. Ms. Visalli stated that the costs are expected to rise over seven percent. More information on this will be presented in the next several SEBC meetings. In presenting the numbers, he requested that the cost of last year's increase that the state absorbed and the cost of this year's increase be illustrated. Lastly, he wanted to know if the health plan operated under Delaware Code Title 29, Chapter 52 Health Care Insurance. Ms. Visalli stated that it does. His only concern with the CDH plan is that lower paid employees may enroll in a lower cost plan and not be completely educated on how to use the benefits.

**Other Business**

None.

Ms. Visalli stated the Committee had two health care appeals to discuss in Executive Session. They would go back into Public Session to vote on the outcome of the appeals, but there wouldn't be any other business.

A reminder was given that the next SEBC meeting is scheduled for Friday, February 25, at 2:30 p.m. She then asked for a motion to go into Executive Session. Justice Berger made the motion and Mr. Gregor seconded the motion. The motion carried upon unanimous voice approval at 3:22 p.m.

At 4:00 p.m. the public session reconvened. For the health appeal that was continued from the prior meeting, Ms. Lakeman asked for a motion to approve the recommendation not to approve the appeal. Mr. Gregor made the motion and Mr. Smith seconded. Ms. Christiansen and Treasurer Flowers abstained from the vote. Justice Berger, Ms. Visalli, Ms. Vaughn, Mr. Smith and Mr. Gregor voted in favor. The motion passed with majority approval.

For the second health appeal Ms. Visalli asked for a motion to not approve the recommendation for the health appeal but to pay appropriate allowable charges. Mr. Smith made the motion and Treasurer Flowers seconded. Upon unanimous voice vote the motion passed.

Ms. Visalli asked for a motion to investigate the preauthorization process. Mr. Smith made the motion and Ms. Christiansen seconded. The motion passed upon a unanimous voice vote of agreement.

Ms. Visalli asked for a motion to adjourn. Mr. Gregor made the motion and Mr. Smith seconded. Upon unanimous voice approval the public meeting ended at 4:03 p.m.

Respectfully submitted,

Mary K. Thuresson
Administrative Specialist
Statewide Benefits Office, OMB